The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.my.centivo.com or call 1-888-506-1630. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers: $3,500 Individual / $6,400 Family Out-of-Network Providers: $6,400 Individual / $12,800 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Providers: $4,000 Individual / $8,000 Family Out-of-Network Providers: $8,000 Individual / $16,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.my.centivo.com or call 1-888-506-1630 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. Referrals are obtained by the primary care physician.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 Copayment after Deductible	20% Coinsurance	Virtual visits and telephonic visits are the same as in-office visits.
	Specialist visit	$60 Copayment after Deductible	20% Coinsurance	Virtual visits and telephonic visits are the same as in-office visits.
	Preventive care/screening/ immunization	$0 Copayment (Deductible does not apply)	20% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0 Copayment after Deductible	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$0 Copayment after Deductible	20% Coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://www.caremark.com/** or call 1-866-818-6911.	Tier 1 - Generic drugs	Retail: $10 Copayment Mail Order: $20 Copayment	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Deductible applies for prescription drug coverage.
	Tier 2 - Preferred brand drugs	Retail: $35 Copayment Mail Order: $70 Copayment	Not Covered	
	Tier 3 - Non-preferred brand drugs	Retail: $50 Copayment Mail Order: $100 Copayment	Not Covered	
	Tier 4 - Specialty drugs	$150 Copayment	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 Copayment after Deductible	20% Coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	$0 Copayment after Deductible	20% Coinsurance	None
If you need immediate medical attention	Emergency room care	$200 Copayment after Deductible	$200 Copayment after Deductible	Copayment waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	$0 Copayment after Deductible	$0 Copayment after Deductible	All Emergency Services are considered in-network. Non-emergent use of the Emergency room results in an additional $250 penalty. Preauthorization is required for non-emergent Air Ambulance. Urgent care is same as in-network when outside of service area.
	Urgent care	$75 Copayment after Deductible	20% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 Copayment after Deductible	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	$0 Copayment after Deductible	20% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit**: $0 Copayment after Deductible **Partial Day Program**: $0 Copayment after Deductible	20% Coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Inpatient services	$0 Copayment after Deductible	20% Coinsurance	
If you are pregnant	Office visits	$60 Copayment after Deductible	20% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance, and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Failure to obtain preauthorization for childbirth if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery may result in benefits being reduced.
	Childbirth/delivery professional services	$0 Copayment after Deductible	20% Coinsurance	
	Childbirth/delivery facility services	$0 Copayment after Deductible	20% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$0 Copayment after Deductible	20% Coinsurance	Limited to 90 visits/year combined with Private Duty Nursing. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Rehabilitation services	$60 Copayment after Deductible	20% Coinsurance	Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$60 Copayment after Deductible	20% Coinsurance	
	Skilled nursing care	$0 Copayment after Deductible	20% Coinsurance	Limited to 90 visits/year combined with Inpatient Medical Rehabilitation. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Durable medical equipment	$0 Copayment after Deductible	20% Coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Hospice services	$0 Copayment after Deductible	20% Coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Coverage limited as required by PPACA.
	Children's glasses	Not Covered	Not Covered	Not a covered service under this plan.
	Children's dental check-up	Not Covered	Not Covered	Coverage is limited to an oral risk assessment each year as required by PPACA.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- **Cosmetic Surgery**
- **Dental Care (Adult)**
- **Long-Term Care**
- **Non-emergency care when traveling outside the U.S.**
- **Routine Eye Care (Adult)**
- **Routine Foot Care**
- **Weight Loss Programs**

* For more information about limitations and exceptions, see the plan or policy document at https://my.centivo.com

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• **Acupuncture** • **Bariatric Surgery** (Limited to 1 per lifetime)	• **Chiropractic Care** • **Hearing Aids** (Limited to age 18 & younger - 1 hearing aid per every 3 calendar years) • **Infertility Treatment** (Artificial Insemination only)	• **Private Duty Nursing** (Home Only - Limited to 90 visits/year combined with Home Health Care)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or Affordable Care Act | U.S. Department of Labor (dol.gov) or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.CMS.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Centivo at 1-888-506-1630. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-506-1630.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-506-1630.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-506-1630.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-888-506-1630 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-506-1630.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-506-1630.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-506-1630.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-888-506-1630.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,520**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

The plan would be responsible for the other costs of these EXAMPLE covered services.